Indochinese
Refugee Reports

Information Exchange Project American Public Welfare Association
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IN THIS ISSUE:

DELIVERY OF AID TO CAMBODIA REMAINS INSUFFICIENT

By all accounts, the fate of perhaps millions of Cambodians continues to hinge on finding mechanisms acceptable to the Vietnamese-installed Heng Samrin government for expanding aid delivery within Cambodia. Under current methods of delivery by sea and by air, at most only 12-13,000 tons of food and medicine a month can be delivered to starving Cambodians who are too weak to make the trek to the Thai border, where various relief agencies continue to distribute food and medicine. Most of the aid currently arriving in Cambodia -- less than half the amount needed merely to maintain the starving Cambodian population -- is restricted to delivery within a 100-mile radius of the capital, Phnom Penh. It is believed that even the recent agreement by the Vietnamese government, announced at the United Nations on November 5, to allow ships to bring aid up the Mekong River will not sufficiently increase aid delivery to prevent widespread death.

In spite of grim forecasts, however, officials of the International Committee

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of the Red Cross (ICRC) and UNICEF believe that those agencies will be able to deliver 15,000 tons of aid by the end of November; 20,000 by early December; and 30,000 by the end of the year. Experts warn that relief agencies will still need to make up for the months of inadequate delivery of aid. Senator Max Baucus (D-Mont.) told the Senate Foreign Relations Subcommittee on International Operations on November 8 that beyond the first six months of initial assistance, perhaps up to 2,500 tons of food and medical aid would be needed each day for a period of up to two years in order to restore the Cambodian population to a minimum standard of health.

U.S. Seeks Expanded Options

On October 31, Senators John Danforth, Max Baucus and James Sasser reported to the Senate Judiciary Committee on their trip to Thai border camps and to Phnom Penh, where they first proposed the idea of a land bridge of truck convoys to deliver aid to various points throughout the country. The Heng Samrin government rejected that proposal soon after the senators departed the country. Senator Danforth told the Committee, "I would like to say as clearly and persuasively as I can: there are no roadblocks [to delivering aid], there is only one roadblock -- and that roadblock is political. That is the one issue that we must focus on."

Officials of the World Food Program, a United Nations agency, assured the senators that trucks could begin moving into Cambodia within 3-5 days of receiving permission to do so. When persistently questioned by Judiciary Committee members about what else the U.S. can do, Senator Danforth had no suggestion other than "to keep this issue alive in every forum we can find -- week after week, until those trucks start rolling." Judiciary Committee Chairman Ted Kennedy told the senators, "There is no lack of willingness by Congress to respond."

It is estimated that 400 to 600 ten-ton trucks will be needed for the aid convoy, which would cross into Cambodia from Thailand along Highways 5 and 6, heading toward Phnom Penh. Food and medicine would be dropped off at storage points along the way for further distribution. Trucks returning to Thailand for additional aid could distribute food delivered by air into Phnom Penh.

Although the United States has tried to act primarily in support of international agencies and private voluntary organizations, Secretary of State Cyrus Vance told a press conference on October 31 that the U.S. has had ongoing contacts with the Vietnamese, the Soviet Union, the Chinese and "others" to expedite and expand relief efforts. Considerable criticism has been voiced about the failure of the United States to bring pressure to bear on Vietnam through its chief supporter, the Soviet Union, to prevent further obstruction of relief efforts. During the November 8 hearing of the Senate Foreign Relations Subcommittee on International Operations, Senator Charles Percy obliquely linked consideration of the Salt Treaty by that committee to future Soviet efforts to ease the Cambodian situation. Under questioning, Senator Danforth told Percy that the treaty "obviously has to be viewed within the light of our total relationship with the Soviet Union," although SALT II is not specifically linked to any particular behavior on the part of the U.S.S.R. Senator Percy responded, "I don't think there's a word of what you've said that 100 senators would not agree to. We're just flatly, simply saying, this is a factor."

Testifying before the same subcommittee on that day, Acting Coordinator for Refugee Affairs Matthew Nimetz outlined eleven possible measures to expand current relief efforts.

Stressing that the U.S. would be working with the ICRC and UNICEF, Nimetz suggested as possible actions: maximizing the use of the Mekong River route; encouraging a French proposal to repair the railway system in Cambodia; seeking an increase in ICRC/UNICEF and voluntary agency personnel within Cambodia; increasing the number of air flights to Phnom Penh; seeking permission to use additional airports for wider distribution of aid; urging the cooperation of the Vietnamese and the Soviet Union to increase all access routes; continued consultations with other governments to increase ICRC/UNICEF financial support; and encouraging and supporting American voluntary agencies to bring additional personnel and supplies to border camps in Thailand.

Future efforts in the U.S. to improve relief delivery should include a plan to mobilize volunteer support for relief agencies, Senator Paul Tsongas told the subcommittee. The Oxford Committee for Famine Relief (OXFAM), a London-based organization with an American branch, is receiving about 225 calls a week from potential volunteers, according to Tsongas. The Peace Corps is studying the possibility of sending experienced volunteers to assist relief agencies in Thailand and in Cambodia.

Stalemate May End Soon

Acting Coordinator for Refugee Affairs Matthew Nimetz told the subcommittee that authorities in Phnom Penh are showing signs of being more receptive to cooperation with international relief agencies. "We are informed that they have approved multiple flights a day into Phnom Penh and that they are setting up their own relief committee to serve as a liaison with ICRC and UNICEF officials to coordinate distribution." Nimetz also told the subcommittee that two truck convoys may be allowed to travel beyond the current 100-mile radius of Phnom Penh to which they have been restricted in delivering aid.

Senators Danforth, Baucus and Sasser were part of the U.S. delegation to a United Nations pledging conference on November 5, at which the international community pledged $210 million in cash and kind assistance to Cambodia. Senator Danforth reported to the Senate Foreign Relations subcommittee that after meeting with the Phnom Penh ambassador to the Soviet Union following that conference he was "enheartened" at an apparent growing willingness to negotiate on the idea of a truck convoy. Danforth suggested that the ICRC and UNICEF should continue direct negotiations with the Heng Samrin government on this issue.

Congress Acts Swiftly

Congress acted swiftly to approve President Carter's October 24 promise of $69 million in relief for Cambodia. On October 25, the House passed H.R. 4955, which authorizes supplemental refugee and migration assistance for Department of State refugee programs. Under an amendment sponsored by Clement Zablocki, the House agreed to authorize the use of $30 million in aid relief to Cambodia. When the Senate took up consideration of its version of the supplemental authorization, S. 1668, it substituted the text of its bill and passed H.R. 4955 as an amended substitute. The Senate, through an amendment sponsored by Senator Danforth for himself and others, agreed to authorize $30 million in relief in addition to the amount authorized for use in existing funds, thus approving President Carter's aid proposal.

In an unusual move, conferees meeting on October 31 on the foreign assistance appropriations bill, H.R. 4473, inserted the additional $30 million into that bill, thus making the money immediately available once both measures are enacted. Without that provision, a supplemental appropriation would have been necessary. The conference on the foreign assistance

bill is expected to begin again during the week of November 12.

Aid Thus Far

The UN estimates that since regular aid shipments began, some 10,000 tons of food and medical aid have reached Cambodia. Flights arriving daily in Phnom Penh since October 13 have carried 14 tons of food and medical supplies at most on each trip. Barges chartered by the Oxford Committee for Famine Relief (OXFAM) carry aid to the port of Kompong Som, where logistical problems (docks in disrepair, insufficient personnel with the strength to do heavy lifting) have slowed further distribution of food and medicine.

It is estimated that the use of the Mekong River to deliver aid to Phnom Penh will enable an estimated 8,000 tons of additional aid to arrive each month. Secretary of State Cyrus Vance told a press gathering on October 31 that only "speedy and massive deliveries by all possible routes will provide the relief which is needed." Some senators have voiced support for a Berlin-type airlift of supplies into various parts of the country, and Acting Coordinator for Refugee Affairs Matthew Nimetz told the Senate Foreign Relations Subcommittee on International Operations that an airlift has not been ruled out.

HEALTH PROBLEMS OF INCOMING REFUGEES

Various health problems experienced by incoming Indochinese refugees have caused local communities and their health officials to express a growing concern over the impact that these refugees will have on existing populations and on health resources. For citizens, the concern is what diseases might be transmitted to the public at large. Health officials worry about the strain on medical facilities and on the staff who must cope with increased workloads involved in adequately screening refugees for certain problems. The greatest difficulties are experienced by those communities heavily impacted by the increased numbers of refugees entering the U.S.

In June, HEW Secretary Joseph Califano dispatched a public health service team to investigate reported health problems on the West Coast. As a result of that team's study, and of consequent follow-up, the Center for Disease Control (CDC), an agency of HEW's Public Health Service, has determined that the overwhelming majority of refugees are free of major infectious disease. Where illness exists, it usually presents a personal rather than a public health problem. Tuberculosis, potentially the most serious problem, is regarded as manageable. Most refugee health problems are less threatening, due to sanitation conditions in the U.S. and overall health standards. Problems such as intestinal parasites, anemia, skin conditions, scabies, syphillis, malnutrition and dental disease are not considered cause for alarm in the public.

Integration into the Public Health System

Once approved for admission to the U.S., refugees are moved from their original camps to a transit center where medical screening occurs under the supervision of the Intergovernmental Committee for European Migration (ICEM). There, a brief history is taken, the entire skin surface is examined, and a refugee is observed for certain excludable conditions. Refugees 15 years of age and over are tested for syphillis and given a chest x-ray. Other tests are administered if indicated.

Refugees may be excluded from entry to the U.S. for untreated venereal disease, active TB, infectious leprosy, and certain mental disorders. Those who are excluded are put on medical hold while their conditions are treated. Waivers for certain active but non-infectious conditions can be obtained in specific circumstances, where the

disease begins to respond to initial treatment and sponsors in the U.S. pledge to ensure that medical care will continue in the U.S.

Generally, refugees leave for this country within a few days of passing the exam. When they leave the transit camp, they are given two folders to hand-carry: one contains their chest x-ray and medical records (Form 157), the other contains INS and voluntary agency documents.

Refugees are met at the port of entry by CDC Quarantine Officers, who examine their records and forward copies to the appropriate local health agencies. If a refugee has an active (but non-infectious) disease, the quarantine officer also alerts the local health agency by phone. Once refugees reach their final destination, their sponsors assist them in contacting the local health department and in entering a regular program of care. If a refugee fails to contact the local health center, the agency attempts to locate that individual in the community.

In the last month the Public Health Service has improved its system of coordinating national and local care initiatives for Indochinese refugees. A complete text of guidelines for health care delivery, most of which have been in effect for the last month, will soon be mailed to state and local health officials to ensure that adequate channels of communication are used and information is disseminated. This document will help officials responsible for refugees:

. be more aware of the overseas screening process and the system for notifying local agencies of conditions requiring follow-up;

. anticipate various types of refugee problems and the services required;

. understand that refugees do not represent a serious threat to public health;

. be more aware of existing resources.

Assessing the Public Health Threat

People who are aware of sometimes less than ideal health and sanitation conditions in crowded Southeast Asian refugee camps understandably raise concerns about any possible threat posed to U.S. citizens by a large influx of refugees into local communities.

TB, the one condition considered potentially serious, responds quickly to adequate treatment. CDC data show that one to two percent of refugees who have entered the country during 1979 have active TB, but in its non-infectious form. To date, the CDC reports that there have been no known cases of infectious TB in the refugee population. As noted, active TB is an excludable condition: refugees so classified must remain in Asia until their TB becomes inactive. Refugees with active TB who are non-contagious can also be admitted if their sponsors pledge in writing to seek immediate treatment for the refugees. Local health authorities are then alerted.

Reportedly, the incidence of inactive TB may be distorted, because many refugees receive a BCG vaccine, which is known to cause the body to produce antigens. These in turn cause a positive skin test reaction.

Frequently, inconclusive or even incorrect evidence of a disease related to the presence of refugees in a local community leads to a public outcry. Recent scares caused by some cases of diptheria in California and cholera in Louisiana are good examples to consider.

The diptheria scare in California involved a two-year old Hmong girl in the Lumphini refugee transit center in Bangkok who showed signs of that disease. Within two days, the flow

of new refugees into the camp was halted. Seven hundred people who had possibly had contact with the girl or her family were isolated for observation. Active surveillance of refugees arriving in the U.S. from that camp was begun. Of 96 refugees arriving in Los Angeles, seven showed some possible signs of diptheria and were cultured for the disease. One case proved positive: a 32-year-old man who had been allowed to travel to Denver before results were available. He has since been hospitalized and does not appear to have infected anyone else. CDC officials state that since the episode, CDC policy has changed: patients will now be detained until all such culture results are complete. It is also expected that foreign screening will detect most future cases before they reach this country. In any event, diptheria is not considered a significant public health risk in this country, because almost everyone is immunized. A diptheria vaccine is usually included in the standard tetanus shot.

The scare in California is a good example of a possible problem that was immediately monitored. It is also evidence of the ability -- and willingness -- of CDC to alter procedures where necessary to provide stricter safeguards for the public health.

The cholera "scare" in Louisiana is an example of incorrect information leading to alarm over the presence of refugees in the U.S. In 1978, there was a sudden outbreak of cholera in southwest Louisiana. It was the first appearance of the disease in the U.S. since 1973 (the first time in Louisiana since 1873). Some saw a connection between this outbreak and the presence of Vietnamese who fished in local waters. CDC epidemiologists assigned to the state, however, determined that the strain of cholera in Louisiana was of an altogether different genetic type than that found in Indochina. Although cholera is widespread in Asia, there is little risk of transmission within this country. Cholera is not believed to have a carrier stage, and generally, patients cease to be contagious within two weeks of contracting the illness.

A problem that will warrant close attention and further study involves the increasing occurence of inactive hepatitus B in Indochinese refugees. It must be stressed that the risk to the general population is considered small. Hepatitus B is not a highly contagious disease, because transmission is unlikely to occur via environmental surfaces or through casual social contact. Of those who contract it, however, about 5 percent remain carriers for life. A preliminary study of Canadian refugees shows that 12 percent are carriers of Hepatitus B. Only .3 percent of the U.S. population are carriers, and the additional numbers of refugee arrivals are expected to increase the pool of carriers by a small percentage. The CDC maintains that proper care and management of individual cases minimizes any increased risk of transmitting the disease to the U.S. population.

Hepatitus B virus can be found in the blood and other body fluids. It is generally transmitted through blood transfusion and non-sterile needles. There has been some suggestion that Hepatitus B could be transmitted during dental work if a physician has a small cut in the hand through which blood in the saliva could enter the body. This route of infection has not been carefully studied and warrants further investigation.

Improving the System

While some of the medical problems associated with the influx of Indochinese refugees to this country are exaggerated, other problems are very real. Many states and counties have received so many refugees that their resources have been stretched to the

breaking point. There are not enough doctors able or willing to treat refugees, not enough translators to communicate with them, not enough staff to keep track of them.

HEW is working on these problems. To help relieve some of the administrative burdens placed on highly impacted local health departments, the Public Health Service has offered to make its facilities and personnel available to local health departments.

Other problems stem from poor communication between international, national and local health authorities. Refugees have arrived at ports of entry with incomplete records or without records altogether; x-rays and other tests have had to be repeated. Local agencies report that records have not always reached them or have been sent to the wrong place. The CDC sometimes does not receive follow-up reports from the local health departments.

The CDC has made a number of changes recently that should improve the situation. As of October 25, nine additional CDC officials were in place in transit camps in Hong Kong, Singapore, Thailand and Malaysia. These officers will oversee and upgrade the entire screening program and introduce new immunization procedures. Twelve new quarantine officers were added at U.S. ports of entry in late September. Soon refugees will be given special letters in their own language to encourage them to visit local health agencies.

For surveillance and follow-up to be effective, however, information must move both ways: from the CDC down to the local agencies, and back up again. This has not always been happening. For instance, since the first of the year, the CDC has identified 2,100 refugees with either active or inactive TB. This information was transmitted to the appropriate local agencies. Of this number, the CDC has received dispositions on only 1/3 of the cases, and roughly half are patients with active TB.

Other problems remain in the system -- or perhaps outside the system, and beyond any single organization's responsibility. For example, it is extremely difficult to keep track of secondary settlements. Frequently, refugees change address or move out of the area suddenly and fail to inform health authorities. When they arrive in other areas, they may have no records and often little idea of where they were last treated.

Although many of these problems do not yield to easy solutions, improved communication and sharing of resources between all levels of government as well as voluntary agencies offers the best promise of resolution△

(Author: Donald A. Stewart, Consultant)

Recent Developments

AMBASSADOR CLARK RESIGNS

Effective November 1, Ambassador Dick Clark resigned from his position as head of refugee programs at the Department of State. Counselor of the State Department, Matthew Nimetz, is Acting Coordinator for Refugee Affairs. An announcement of Clark's replacement is expected soon△

STATUS OF DOMESTIC REFUGEE PROGRAM FUNDING

Public Law 96-86, the resolution which continues funding for major federal agencies and programs whose appropriations bills did not pass Congress by the start of the new fiscal year on November 1, is due to expire on November 20. Just a week short of that date, it is expected that the legislative authority for funding of domestic programs for refugees will be continued through an extension of the current resolution. Because the House is on recess during the entire week of Thanksgiving, action is expected during the week of November 12.

Refugee Act of 1979

The Refugee Act of 1979, intended to provide a permanent authority for refugee admissions and assistance, may soon reach a House vote. A stalemate between the House Foreign Affairs and Judiciary Committees over jurisdiction of the bill has now ended with the Foreign Affairs Committee decision not to exercise its jurisdiction through sequential referral of the bill. The Judiciary Committee reportedly was to file its report on the bill on Friday, November 9 thus clearing H.R. 2816 for scheduling on the House calendar.

Technically, the report must be available to House members for at least three days before a vote can occur. This rule is sometimes waived by unanimous consent. Given the controversy surrounding some provisions in the House bill, however, it is unlikely that such a waiver would be sought. Because the bill must go to conference after passage by the House, and because the House is on recess for a full week in November, it is likely that the bill will not be signed into law until early December.

IRAP Extension

On October 25, the House passed a bill, H.R. 4955, which authorized supplemental appropriations for Department of State migration and refugee assistance programs. When the Senate took up consideration of this bill, it substituted the text of its own counterpart, S. 1668, and then passed H.R. 4955, amended, on November 2. Senator Alan Cranston of California offered an amendment to the bill, which passed, to extend the IRAP program through September 30, 1981 under the Indochina Migration and Refugee Assistance Act.

In remarks on the floor, Senator Cranston made clear that his amendment was offered to provide authority for the program only in lieu of the Refugee Act of 1979; once that bill is enacted, refugee programs would operate under that authority. Because H.R. 4955 passed the Senate as an amendment in the nature of a substitute for a bill which has already passed the House, the bill can now go either directly to conference or for a vote in the House. Action is expected quickly.

Under whatever legislative authority the refugee program continues to operate, appropriations will probably have to come through a continuing resolution for a period of some months. When the Refugee Act of 1979 passes, a supplemental appropriation to the Labor-HEW FY'80 appropriations bill, H.R. 4389, will be necessary. When that bill went to conference in August, no authority for the Indochinese program existed beyond September 30. For that reason, no funds for the program were included in the bill. Supplemental appropriations will not be sought until the first of the year, and it could take the Congress several months to appropriate additional funds.

Long-term Outlook

The events of the last two months, during which the legislative picture for refugee programs became very complex, are full proof of what supporters of the Refugee Act of 1979 have said all along: that permanent legislative authority for domestic refugee programs is desperately needed. By early December, that authority will probably be signed into law. In the meantime, the Indochinese Refugee Assistance Program will continue to operate under an interim funding measure.

At the time of writing on Friday, November 9, the House Appropriations Committee was meeting to consider the continuing resolution.

EDUCATIONAL FUNDS FOR REFUGEE CHILDREN

Funding for school districts providing services to Indochinese refugee children may be available by January 1, 1980. On November 5, HEW Secretary Patricia Harris sought the approval of the House and Senate Appropriations Committees to reprogram the use of $6 million in existing funds available to HEW to assist elementary and secondary schools impacted by the presence of refugee children. Approval from both the committees is expected to come quickly.

HEW is developing regulations for the special elementary and secondary education program and will seek a waiver of clearance on the normal requirements for promulgating regulations in order to speed up disbursement of the funds. Indications are that the money will go directly to school districts requesting such aid. There will be discretion in the amount to be granted, ranging from $200-350 per refugee child, but taking into account factors other than numbers of refugee children in a district, i.e., a school district's overall financial abilities and resources for serving these children.

Resource Exchange

HEALTH NEWS

Through several issues of its *Morbidity and Mortality Weekly Reports*, the Center for Disease Control has published very valuable information on the health status of Indochinese refugees in the U.S. Interested readers can request those particular issues (Vol. 28, Nos. 33, 39, and 43) by writing the CDC (Distribution Services, Building 1, SB 419, Atlanta, Georgia 30333) or calling the distribution department at 404/329-3210. There is no charge for these government publications.

SENATE REPORT: "THE REFUGEE CRISIS IN SOUTHEAST ASIA"

The report of the Senate Judiciary Committee hearing on July 26 on the Geneva conference and on the refugee situation in Southeast Asia is now available. Testifying at the hearing were Secretary of State Cyrus Vance, (former) Ambassador Dick Clark and Robert Oakley, Deputy Assistant Secretary for East Asian and Pacific Affairs.

Included in the appendices are the text of the seven-point "Orderly Departure" agreement signed by the UNHCR and the government of Vietnam. Of particular interest in the hearing text are questions raised by Senator Thad Cochran concerning the use of ICEM (the Intergovernmental Committee for European Migration) to arrange for refugee transport to the U.S. Correspondence between Senator Cochran and Edward Daly, president of World Airways, and ICEM officials raise concerns about health care needed during flights, as well as the cost and safety of flights as they are currently handled.

The report, Senate No. 96-12, can be obtained by writing the Senate Judiciary Committee Documents Room, Dirksen Senate Office Building, Room 2226, Washington, D.C. 20510.

SCHOLARLY JOURNAL CALLS FOR ARTICLES

The Center for Migration Studies in New York has issued a call for articles for an upcoming issue of the *International Migration Review* to be devoted entirely to research on refugee problems. Articles are sought in several general areas: historical and analytical perspectives of refugees in the twentieth century; refugee behavior and health, including mental health; adjustment and resettlement;

and surveys of refugee populations throughout the world and worldwide programs and policies on refugees.

Interested persons can obtain a refugee research bibliography and further information by writing Professor Barry Stein (guest editor), Department of Social Science, Michigan State University, East Lansing, Michigan 48824, or Dr. S. M. Tomasi, Editor, *International Migration Review*, 209 Flagg Place, Staten Island, New York 10304. Outlines are needed by December 1, 1979, or articles by June 1, 1980△

MENTAL HEALTH NEEDS OF INDOCHINESE REFUGEES

Under a grant from the IRAP Special Programs Office at HEW, the Pennsylvania Bureau of Research and Training conducted a national mental health needs assessment of Indochinese refugees in the spring of this year. Bureau staff surveyed, by questionnaire, over 1,100 organizations familiar with the problems of refugees and conducted site visits to eight IRAP mental health projects to validate results of the survey and to get a more personal look at refugee problems.

In a paper released in July, the Bureau reports its findings on such questions as: What is the frequency of mental health problems among this population? Who serves this population? What are the most common problems? Is one ethnic group, or age group, more at-risk than another?

The twenty-five page report of the Bureau includes a sample of the questionnaire used, a list of the site visits made and a list of respondents to the mailed survey. For a copy of the report, write: Ms. Cynthia Coleman, Bureau of Research and Training, Office of Mental Health, Eastern Pennsylvania Psychiatric Institute, Henry Avenue and Abbottsford Road, Philadelphia, Pennsylvania 19129△

Current Indochinese Refugee Population In The U.S. By State

As of October 31, 1979

1.	Alabama	1,421
2.	Alaska	214
3.	Arizona	1,830
4.	Arkansas	1,939
5.	California	36,035
6.	Colorado	5,478
7.	Connecticut	2,269
8.	Delaware	168
9.	District of Columbia	2,704
10.	Florida	5,477
11.	Georgia	2,220
12.	Hawaii	2,120
13.	Idaho	430
14.	Illinois	8,721
15.	Indiana	1,317
16.	Iowa	2,231
17.	Kansas	3,312
18.	Kentucky	1,296
19.	Louisiana	3,888
20.	Maine	391
21.	Maryland	7,920
22.	Massachusetts	2,433
23.	Michigan	4,552
24.	Minnesota	6,587
25.	Mississippi	862
26.	Missouri	2,485
27.	Montana	613
28.	Nebraska	1,629
29.	Nevada	1,416
30.	New Hampshire	184
31.	New Jersey	2,188
32.	New Mexico	970
33.	New York	7,043
34.	North Carolina	2,145
35.	North Dakota	421
36.	Ohio	3,609
37.	Oklahoma	4,210
38.	Oregon	6,768
39.	Pennsylvania	10,747
40.	Rhode Island	1,387
41.	South Carolina	927
42.	South Dakota	164
43.	Tennessee	2,363
44.	Texas	25,485
45.	Utah	2,145
46.	Vermont	58
47.	Virginia	7,830
48.	Washington	9,373
49.	West Virginia	215
50.	Wisconsin	3,361
51.	Wyoming	139
52.	Virgin Islands	12
53.	Guam	349
54.	Puerto Rico	29
55.	Other & Unknown	1,356
	TOTAL:	161,446

NB. These figures are based on January 31, 1979, alien registrations, adjusted for underregistration; plus new refugee arrivals initially resettled in State; plus/minus estimated net inflow/outflow from secondary migration between States.

Source: Office of Refugee Affairs, HEW/SSA